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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. **2010-360**

13 **KYNETHA KAY TURNER**  
51 Esperanza Avenue, Apt. F  
Sierra Madre, CA 91024

**A C C U S A T I O N**

14 Registered Nurse License Number 597633

15 Respondent.

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17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation  
20 solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing  
21 ("Board"), Department of Consumer Affairs.

22 2. On or about April 9, 2002, the Board issued Registered Nurse License  
23 Number 597633 to Kynetha Kay Turner ("Respondent"). The license will expire on October 31,  
24 2011, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2725 states, in pertinent part:

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

1 (d) Nothing in this section shall be construed to require approval of  
2 standardized procedures by the Division of Licensing of the Medical Board of  
California, or by the Board of Registered Nursing.

3 (e) No state agency other than the board may define or interpret the  
4 practice of nursing for those licensed pursuant to the provisions of this chapter, or  
develop standardized procedures or protocols pursuant to this chapter, unless so  
5 authorized by this chapter, or specifically required under state or federal statute.  
"State agency" includes every state office, officer, department, division, bureau,  
6 board, authority, and commission.

7 5. Code section 2764 provides, in pertinent part, that the expiration of a  
8 license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding  
9 against the licensee or to render a decision imposing discipline on the license. Under Code  
10 section 2811, subdivision (b), the Board may renew an expired license at any time within eight  
11 years after the expiration.

12 6. Code section 2761 states, in pertinent part:

13 The board may take disciplinary action against a certified or licensed nurse  
14 or deny an application for a certificate or license for any of the following:

15 (a) Unprofessional conduct, which includes, but is not limited to, the  
following:

16 (1) Incompetence, or gross negligence in carrying out usual certified or  
17 licensed nursing functions.

#### 18 REGULATORY PROVISIONS

19 7. California Code of Regulations, title 16, section ("Regulation") 1442  
20 states:

21 As used in Section 2761 of the code, 'gross negligence' includes an  
22 extreme departure from the standard of care which, under similar circumstances,  
would have ordinarily been exercised by a competent registered nurse. Such an  
23 extreme departure means the repeated failure to provide nursing care as required  
or failure to provide care or to exercise ordinary precaution in a single situation  
24 which the nurse knew, or should have known, could have jeopardized the client's  
health or life.

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1 **COST RECOVERY**

2 8. Code section 125.3 provides, in pertinent part, that the Board may request  
3 the administrative law judge to direct a licensee found to have committed a violation or  
4 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation  
5 and enforcement of the case.

6 **BACKGROUND**

7 9. At all times herein mentioned, Respondent was employed as a nurse in the  
8 labor and delivery unit at Whittier Hospital Medical Center ("WHMC") in Whittier, California.

9 10. On or about February 23, 2005, at approximately 0530 hours, Patient A  
10 was admitted to WHMC for a scheduled elective cesarean section for a macrosomia (large) baby.  
11 At approximately 0535 hours, Respondent, the admitting nurse for Patient A, noted that a fetal  
12 monitor was placed on Patient A. At 0550 hours, Respondent reviewed the fetal monitoring strip,  
13 noting minimal variability and possible late deceleration.<sup>1</sup> At 0604 hours, Respondent noted  
14 decelerations lasting 60 seconds and increased variability. From the time of Respondent's  
15 knowledge of the ominous fetal heart rate at 0550 hours, to the transfer of Patient A's care to the  
16 on-coming nurse at approximately 0625 hours, Respondent had not notified the attending  
17 physician of the status of Patient A or the fetus, and was unaware whether anyone else had.<sup>2</sup>  
18 Respondent did not initiate oxygen to Patient A and took no action to expedite her delivery. An  
19 unresponsive infant was delivered at 0758 hours, and pronounced dead at 0820 hours.

20 **FIRST CAUSE FOR DISCIPLINE**

21 (Gross Negligence)

22 11. Respondent's registered nurse license is subject to disciplinary action  
23 under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on  
24 or about February 23, 2005, while working at WHMC as a registered nurse in labor and delivery,

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26 1. Variability determines if the fetus is receiving sufficient oxygen, and is an indication of fetal stress.

27 2. According to WHMC's *Standard of Care, Policy #300*, "Fetal heart rate assessment by continuous  
28 electronic fetal monitor will be initiated within 20 minutes of patient's placement in the labor and delivery area.  
The parameters are: baseline fetal heart rate, periodic changes, variability. . . . All assessment parameters will be  
communicated to the attending physician."

Respondent was guilty of gross negligence as set forth above in paragraph 10, within the meaning of Regulation 1442, and as follows:

- a. Respondent failed to administer oxygen to Patient A.
- b. Respondent failed to notify Patient A's attending physician, from the time of her admission of Patient A to WHMC at approximately 0535 hours, to the end of Respondent's shift at 0630 hours, of the status of Patient A or Patient A's infant.

**SECOND CAUSE FOR DISCIPLINE**

(Unprofessional Conduct)


12. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on or about February 23, 2005, while on duty as a registered nurse at WMHC, Respondent committed acts constituting unprofessional conduct, as set forth above in paragraphs 10, and 11, subparagraphs (a) and (b).

**PRAYER**

**WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 597633, issued to Kynetha Kay Turner;
2. Ordering Kynetha Kay Turner to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: 2/2/10

  
LOUISE R. BAILEY, M.Ed., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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